STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENTWOOD AT HOBART	1420 ST MARY CIRCLE HOBART, IN46342

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R0000	This visit was for the Investigation of Complaint IN00090754. Complaint IN00090754 - Substantiated. State residential deficiencies related to the allegations are cited at R0116, R0241, and R0349. Survey date: June 16, 2011 Facility number: 002627 Provider number: 002627 AIM number: N/A Survey team: Kathleen (Kitty) Vargas, RN, TC Lara Richards, RN Census bed type: Residential: 110 Total: 110 Census payor type: Other: 110 Total: 110 Sample: 5 These state findings are cited in accordance with 410 IAC 16.2. Quality review completed 6/21/11 by	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Jennie Bartelt, RN.			
R0116	(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to implement the personnel policy related to the lack of reference checks for 4 of 4 employee records reviewed. (Resident Care Assistant #1, Resident Care Assistant #2, Resident Care Assistant #3 and Resident Care Assistant #4) Findings include: The employee files were reviewed on 6/16/11 at 1:15 p.m. A total of four employee files were reviewed. 1. RCA (Resident Care Assistant) #1 was hired on 1/14/11. There were no reference checks available for review in the	R0116	***Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right to correct) on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.***	07/01/2011

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	employee's file. 2. RCA #2 was hired on 1/7/11. There were no reference checks available for review in the employee's file. 3. RCA #3 was hired on 2/16/11. There were no reference checks available for review in the employee's file. 4. RCA #4 was hired on 4/12/11. There were no reference checks available for review in the employee's file. The policy titled, "Hiring Process Overview" was provided by the Resident Care Director on 6/16/11 at 2:05 p.m. She indicated the policy was current. The policy indicated that reference checks and credentials had to be verified prior to the start of employment. Interview with the Business Office Manager on 6/16/11 at 2:15 p.m. indicated two reference checks were required to be obtained for all prospective employees, prior to the start of employment. She also indicated there were no reference checks obtained for RCA #1, RCA #2, RCA #3 and RCA #4. She indicated two reference checks should have been obtained for the four employees. This state finding relates to Complaint		**R 116 Personnel - Noncompliance** *What corrective action(s) will be accomplished for those employee files found to have been affected by the alleged deficient practice?* · Employee #1, #2, #3, #4 reference check completed by the BOD on June 20th, 2011 *How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* · The Business Office Director and/or designee will audit Employee files for reference checks by 7/1/ 2011 if any are found to be out of compliance they will be corrected by 7/1/11. *What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?* · Department heads who participate in the hiring process have been educated by The Executive Director 6/20/11 regarding the community policy and are responsible for completing two reference checks on new hires prior to offering a position *How will the corrective actions be monitored to ensure the deficient*	

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	IN00090754.		*practice will not recur, i.e., what quality assurance programs will be put in place?* · The business office director and/ or designee will audit new employee files within 24 hours of hire to ensure compliance · Audits will be reviewed at quarterly QA meetings for compliance for a minimum of two quarters. · The regional team will monitor for compliance on random visits to the community and during the annual comprehensive review. *By what date will these systemic changes be implemented?* · 7/1/11	
R0241	(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.			
	Based on record review and interview, the facility failed to ensure medications were administered as ordered by the physician, related to the administration of Aricept at twice the recommended dosage, for 1 of 4 residents reviewed who have medications administered by facility staff, in a sample of 5. (Resident #B) Findings include:	R0241	**R 241 Health Services offense** *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* · Resident #B moved out of community on 5/27/11 *How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* · RCD and/	07/08/2011

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	The record for Resident #B was reviewed on 6/16/11 at 11:20 a.m. The resident had diagnoses that included, but were not limited to, Alzheimer's disorder, dementia, confusion and psychiatric fear. The resident's admission orders, dated 3/25/11, indicated the resident was to receive Aricept (a medication for the treatment of Alzheimer's Disease) 5 mg (milligrams) by mouth twice daily. The form titled, "Healthcare Provider Communication Form," was dated 4/15/11. It was a form used by the facility to communicate with the physician via fax. The section of the form titled "Concern reason for visit/communication" indicated "Possible med. (medication) error. MAR (medication administration record) read Aricept 5 mg po (by mouth) BID ((twice daily) Pharmacy stating sent Aricept 10 mg PO Daily. Pharmacy changed dose without notifying staff. Unaware if true med error no longer have empty card. Resident has no complaint of anything. MAR changed to match directions on medication card." Under the section titled "Healthcare provider findings and recommendations," the physician indicated, "should receive Aricept 10 mg po daily" the physician's name was written and it was dated 4/18/11.		or designee will audit physician orders and MARs for residents. If any discrepancies are discovered, the residents will be assessed for adverse reactions and their physicians and families will be notified by 7/8/11 *What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?* · Community licensed nurses and qualified medication aides will be reeducated on the community policy regarding medication administration / errors by the resident care director on 7/8/11. · Community licensed nurses and qualified medication aides will be skill tested to demonstrate competency by the Resident care director and/ or designee by 7/8/11 *How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?* · The RCD and/ or designee will complete random audits of physician orders / MARs monthly, on 10% of our community population. · Audits will be reviewed at quarterly QA meetings for compliance for a minimum of two quarters. · The regional team will monitor for compliance on random visits to the community and during the annual comprehensive process review. *By what date will these systemic changes be*	

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			implemented? · 7/3/11	

Review of the Service Notes dated 3/25/11 through 4/26/11 indicated no documentation of a incorrect dose of Aricept being administered. There was no documentation to indicate the lack of adverse side effects of the incorrect dose of Aricept.

The form titled "Event Management Report- Medication Occurrence" was provided by the Resident Care Director on 6/16/11 at 11:15 a.m. She indicated a medication administration error had occurred with Resident #B. The form indicated, "MAR read Aricept 5 mg PO BID. Pharmacy stating they sent Aricept 10 mg PO Daily so staff was giving Aricept 10 mg PO BID."

The "2010 Nursing Spectrum Drug Handbook" indicated the indications and dosages for Aricept as follows:
For mild to moderate Alzheimer's Disease, Adults: Initially, 5 mg po daily at bedtime. After 4 to 6 weeks, may increase dosage to 10 mg.
For severe Alzheimer's Disease, Adults: 10 mg po daily.

Interview with the Resident Care Director on 6/16/11 at 12:15 p.m. indicated the pharmacy had provided Aricept 10 mg upon the resident's admission to the

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	facility on 3/25/11. She indicated the pharmacy always labels the medication with the medication name and the dose of the medication. She indicated the wrong dose of the Aricept was administered by the facility staff twice daily from 3/25/11 until 4/15/11. The resident received 10 mg of Aricept twice daily for a total of 20 mg per day instead of the physician's ordered dose of 5 mg of Aricept twice daily for a total of 10 mg per day. She indicated the error was not noted until family was called to obtain another prescription of Aricept and indicated it was not time for a medication refill. She indicated staff had not identified the medication error despite the dose on the medication package not matching the physician's order. She indicated the error was not discovered timely by facility staff. Continued interview with the Resident Care Director on 6/16/11 at 12:15 p.m. indicated there was a lack of documentation in the Service Notes of the assessment of the resident for adverse side effects after the medication error was noted. She indicated there should be documentation of the assessment of the resident for adverse side effects of the medication error. This state finding relates to Complaint IN00090754.			

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R0349	(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure the clinical record for each resident was complete and accurate related to the lack of documentation of a resident's response to a medication error for 1 of 5 resident records reviewed in a sample of 5. (Resident #B) Findings include: The record for Resident #B was reviewed on 6/16/11 at 11:20 a.m. The resident had diagnoses that included, but were not limited to, Alzheimer's disorder, dementia, confusion and psychiatric fear. The resident's admission orders, dated 3/25/11, indicated the resident was to receive Aricept (a medication for the treatment of Alzheimer's Disease) 5 mg (milligrams) by mouth twice daily. The form titled, "Healthcare Provider Communication Form," was dated	R0349	**R-349 Clinical records noncompliance** *What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?* · Resident #B moved out of community on 5/27/11 *How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* · RCD and/or designee will audit service notes for any resident who has had a suspected or confirmed medication errors to ensure that the event is properly documented by 7/8/11and ongoing *What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?* · Community licensed nurses and qualified medication aides will be reeducated on the community policy regarding documentation of medication errors by _7/8/11 *How will the*	07/08/2011

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	4/15/11. It was a form used by the facility to communicate with the physician via fax. The section of the form titled "Concern reason for visit/communication" indicated "Possible med. (medication) error. MAR (medication administration record) read Aricept 5 mg po (by mouth) BID ((twice daily) Pharmacy stating sent Aricept 10 mg PO Daily. Pharmacy changed dose without notifying staff. Unaware if true med error no longer have empty card. Resident has no complaint of anything. MAR changed to match directions on medication card." Under the section titled "Healthcare provider findings and recommendations," the physician indicated, "should receive Aricept 10 mg po daily" the physician's name was written and it was dated 4/18/11. Review of the Service Notes dated 3/25/11 through 4/26/11 indicated no documentation of a incorrect dose of Aricept being administered. There was no documentation to indicate the resident's response to the incorrect dose of Aricept. There was no documentation if the resident had the presence or the absence of adverse side effects from the incorrect dose of Aricept. The form titled "Event Management Report- Medication Occurrence" was		*corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?* · The RCD and/ or designee will complete random audits of resident service notes monthly, on 10% of our community population. · Audits will be reviewed at quarterly QA meetings for compliance for a minimum of two quarters. · The regional team will monitor for compliance on random visits to the community and during the annual comprehensive process review. *By what date will these systemic changes be implemented?* · 7/3/11	

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	provided by the Resident Care Director on 6/16/11 at 11:15 a.m. She indicated a medication administration error had occurred with Resident #B. The form indicated, "MAR read Aricept 5 mg PO BID. Pharmacy stating they sent Aricept 10 mg PO Daily so staff was giving Aricept 10 mg PO BID." The "2010 Nursing Spectrum Drug Handbook" indicated the indications and dosages for Aricept as follows: For mild to moderate Alzheimer's Disease, Adults: Initially, 5 mg po daily at bedtime. After 4 to 6 weeks, may increase dosage to 10 mg. For severe Alzheimer's Disease, Adults: 10 mg po daily. Interview with the Resident Care Director on 6/16/11 at 12:15 p.m. indicated the pharmacy had provided Aricept 10 mg upon the resident's admission to the facility on 3/25/11. She indicated the pharmacy always labels the medication with the medication name and the dose of the medication. She indicated the wrong dose of the Aricept was administered by the facility staff twice daily from 3/25/11 until 4/15/11. The resident received 10 mg of Aricept twice daily for a total of 20 mg per day instead of the physician's ordered dose of 5 mg of Aricept twice daily for a total of 10 mg per day. She indicated the			

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	error was not noted until family was called to obtain another prescription of Aricept and indicated it was not time for a medication refill. Continued interview with the Resident Care Director on 6/16/11 at 12:15 p.m. indicated there was a lack of documentation in the Service Notes of the assessment of the resident for adverse side effects after the medication error was noted. She indicated there should be documentation of the assessment of the resident for adverse side effects of the medication error. She indicated staff should have documented the presence or absence of adverse side effects. This state finding relates to Complaint IN00090754.			